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ABSTRACT

This speech sketches a picture of post-natal health care in the United States, circa 1979. Between 1970 and 1976, post-natal infant deaths in the first week after birth dropped 32%. During the same period, the post-neonatal decline was just 12%. Statistics are presented which highlight areas of concern. Variation across states, high incidence in large cities, variation across countries, and the relatively high incidence of infant mortality in the United States are indicated. Figures related to birth hazards of black infants and mothers are given. Morbidity associated with the statistical picture is discussed in terms of an 18-year longitudinal study of two cohorts of births on the island of Kauai. In this study it was found that the reproductive and environmental infant casualties in Kauai amounted to about one-half of those infants conceived and about one-third of the live-born. Federal sources of health funds related to perinatal services are listed. Information relevant to grant application is provided. The presentation concludes with general information related to the improvement of health care services, an increase in available funds, and mandatory functions of the Health Services Administration. (Author/RH)

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IMPROVING INFANT HEALTH*

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The enemy today is not lack of knowledge. It is lack of will. As a nation, we have become complacent about the health of infants and children.

Last year, Dr. Julius Richmond, Assistant Secretary for Health, said that we in America "... have failed to act on the simple truth that the health of a people can be no better than the health of its children."

We have come a long way--and perhaps our complacency is grounded too much in the achievements of the past, rather than the challenges of the future. There's no denying—we have made great strides. Let's look at that record a moment.

Figure 1

As this century opened, infant mortality in America was 100 per 1,000 live births. By the 1930's, we had halved that rate. We had driven it down to 29 by 1950.

The decline slowed over the next 20 years -- by 1970 it was 20.

Figure 2

Then, for reasons no one fully understood, it began once more to drop rapidly: By 1976 it was 15.2; by 1977 it was 14. Provisional data for 1978 show that the decline is continuing.

One reason for the recent decline may well be the knowledge explosion

in the new fields of neonatology and perinatology. Another has been the expansion of perinatal services, training and research.

Statistics tell their story here too: The infant mortality rate for the first 7 days after birth dropped a dramatic 32% between 1970 and 1976. That's due partly to fewer births among women at high risk because of their age or parity, but it's also due to technical improvements in medical care, plus a regionalized approach to providing maternal and neonatal services.

This decline in early post-natal deaths has not been matched by the infant mortality rate for the post-neonatal period, a time when the infant's environment is more important than the specialized care it receives. During the same six-year period, this post-neonatal decline has been just 12%.

Other problems are apparent.

Slide 3 - The 1973 data shows there is considerable variation among States. The range in 1973 was from 25.9 in Mississippi to 12.7 in Utah. The range in 1976 was from 25.3 in the District and 20.8 in Mississippi to 10.0 in Idaho and New Hampshire.[5] Central cities are also problem areas. In 18 of the 26 largest cities, the infant mortality rate was above the national rate for the three-year period, 1968-1970.

Slide 4 - Figure 4 shows the rates for the 56 cities with populations of over 250,000 compared to the U.S. rates.

Slide 5 - Figure 5 shows the range for the same cities in 1973 from a rate of 27.3 in St. Louis to 10.5 in Miami.

Slide 6 - Selected State and city statistics.

While infant mortality rates have generally been declining during the 1970's, rates in the United States still remain higher than those in many other developed countries. These higher infant mortality rates are often accompanied by higher rates of fetal loss, low birth weight and a variety of other maternal and child health problems.

In 1976, the proportion of low-birth-weight infants was over twice as high among black births (13.0 percent) as among white births (6.1 percent).[7] Maternal mortality has decreased markedly in recent years, with a rate of 12.3 per 100,000 live births in 1976, which is less than half of the rate 10 years earlier (31.6 per 100,000 live births in 1965). Yet there were 390 maternal deaths in 1976, and the rate was three times higher for all other than for white (white - 9.0; all others - 26.5).[3]

In 1976, there were 560,672 births to women 19 years of age and under. Nearly 12,000 of these births (11,929) were to girls less than 15 years of age. Fertility rates for all ages continued to decline. Decreases (5 percent or more) were greatest among teenagers (15-17) and (18-19 years).[3]

With these statistics there is an associated morbidity.

A carefully conducted study demonstrates this.

The Kauai study, an 18-year longitudinal study of two cohorts of births on the island of Kauai, has been reported in two volumes: The Children of Kauai (1971) and Kauai's Children Come of Age (1977). This study is representative of the concerns about the outcomes of pregnancy - with an emphasis upon both the perinatal stress and the environment.

Slide 7 - Figure summarizes the first 10 years of the study. In sum, for each 1,000 live births on Kauai, there were an estimated 1,311 pregnancies that had advanced to four weeks gestation, 286 having ended in fetal deaths before 20 weeks gestation and 25 more between 20 weeks and term. The 1,000 live births yielded an estimated 865 surviving children at age two who were free of any observed physical defect requiring special care and who had IQs of at least 85. By age 10, only 660 of these children were functioning adequately in school and had no recognized physical, intellectual, or behavior problem. Thus, during the span of the months of pregnancy and the first decade of life, the reproductive and environmental casualties in this community amounted to about one-half of those conceived and about one-third of the live-born. 45 additional youngsters were identified at age 18 years with serious behavior problems.[6,7]

The Federal Government has responded to these problems and needs in two ways with funds and programs.

I will discuss funding approaches because information on the specific amounts expended for perinatal services is not available. However, we

can look at some national figures and make our own assumptions. For 1976, the most recent year for which detailed data is available, the total expenditures for health in the United States was $139.3 billion. Personal health care spending amounted to $120.4 billion of the $139.3 billion. Children and youth - all persons less than 19 years of age - comprised 33% of the population and accounted for 15% of the total expenditures for personal health care. Further examining the $139.3 billion dollars of personal health care expenditures reveals that almost 30% of the total amount is provided by direct Federal spending. Another 14% of the total is provided by State and local government funding. It will be interesting to watch that percentage over the next few years, in the wake of California's Proposition 13.

Another way to look at health expenditures is that persons 65 and over get 56.5 cents of the Federal dollar, adults 19 - 64 get 35¢ and children get 8.5¢ of the Federal health dollar. Adjusting for the unequal population within each category still demonstrates great disparity. Per capita, the Federal government spends $832.18 per persons 65 and older, $95.00 for adults 19 - 64 years of age, and only $39.87 for the health care of each child in the United States.

One must also remember how Federal money is expended for health care. One method uses the funds to pay for services that are existent, that is, reimbursement. Medicare and Medicaid are examples of reimbursement. The other method may incorporate reimbursement but most of the funds are

expended in developing programs of services for special populations where such services are - nonexistent

or are - limited in quantity

or are - in need of quality improvement

Title V (The Maternal and Child Health Program) and many health project grant programs are examples of this method.

The major source of Federal funds for perinatal services is Title XIX or Medicaid. Each State may include prenatal, delivery and neonatal care in their State plan. The amount expended on these services is unknown though the total Medicaid budget for 1976 was estimated to be $14.5B, of which the Federal share was nearly $8B.

Ambulatory prenatal and infant services are provided by several programs - community health centers, migrant health programs, National Health Service sites, for example - while providing general health services to communities. In some projects, in-patient perinatal services are also provided, though these are more likely provided by Title XIX.

Selected services in the perinatal period are provided by such programs as Title X of the PHS Act which provides comprehensive family planning services and the Department of Agriculture's WIC program, which acting as an adjunct to health programs, provides food and nutrition education to pregnant and lactating women, and infants and pre-schoolers.

Title V, the Maternal and Child Health Program, with 1.2% of the public monies expended for personal health care, has a variety of programs

targeted on the perinatal period. The basic State MCH program provides an array of services including public health nursing, nutrition and social work services, maternity clinics, pediatric clinics, well child follow-up and, in many States, special programs for high-risk women and infants and pregnant adolescents. In addition, Title V, through the States, supports 82 Maternity and Infant Care projects, and 59 Intensive Infant Care projects.

These 82 Maternity and Infant Care projects provide services to an estimated 300,000 patients a year. The 59 intensive infant care projects serve an estimated 65,000 infants a year or about 2% of the infants born in the nation each year.

Our regional approach is augmented in many places by transport systems supported by the Emergency Medical Services of the Bureau of Medical Services. We are also committing additional funds to States whose infant mortality statistics are worse than the national average. These dollars are above and beyond what each State gets through its formula grants.

It's important that we target aid like this because as we have seen, there is considerable variation in infant mortality rates among States.

We will now assist 34 States, including Illinois, with these Improved Pregnancy Outcome programs. We provide up to $400,000 a year for up to five years. The State's Director of Maternal and Child Health directs the effort.

Our goal is to reduce infant and maternal mortality and infant morbidity;

--by improving maternity care;

--by promoting preventive services;

--by regionalizing care in perinatal centers;

--and by coordinating the work of all levels of government.

States must develop a 5-year plan, using existing resources and regionalized services. Services include basic maternity care. Special emphasis is placed on finding high-risk infants and mothers. A spectrum of services is then planned to reduce that risk. This is literally a life-saving service. Some of these infants would die without the special services these regional perinatal centers provide.

Within the Health Services Administration, we also have other programs that have an impact on infant and child health--Community Health Centers, Migrant Health, the Indian Health Service, the National Health Service Corps, the Appalachia Program, the Sickle Cell Programs, Rural and Urban Health Initiatives. This decade has seen the enactment of still more legislation that impacts on infants:

--The Sudden Infant Death Syndrome Program;

--The Hemophilia Program;

--The Genetics Counseling Program.

All of these programs are slowly but surely being linked together into Statewide and community wide systems of care. This linkage is a key element in our overall child health strategy.

In the last few years, more attention has been given to the health status of the 42 million adolescents in the nation (10-19 years). This number is expected to reach 54 million by the year 2000, if present trends continue. While adolescence is one of the healthiest periods of life, there are substantial health problems occurring, including accidents, venereal disease, substance abuse, obesity, and teenage pregnancy.

The improvement of child health is a major focus of the Department, and many efforts are already underway to improve health care services, particularly for adolescents. These include:

- The award of project grants to 150 Community Health Centers to improve adolescent health care.
- The training of primary health care providers in adolescent growth and development.
- The development of 8 centers of expertise in adolescent health for the training of multidisciplines with Title V/MCH funds.
- The expansion of Family Planning services to teens.

The provisions of the Adolescent Health, Services, and Pregnancy Prevention and Care Act were finally enacted last year as a part of the Health Services and Centers Amendments of 1978.

This significant legislation authorized $50 million for fiscal year 1979, $65 million for fiscal year 1980, and $75 million for fiscal year 1981, to assist in the establishment of networks of community-based services for adolescents at risk of unwanted initial and repeat pregnancies, pregnant adolescents, and adolescent parents, particularly those 17 years of age or under.

Provision is made for grants to public and private nonprofit organizations or agencies which provide certain care and other supplemental services. Care services include pregnancy testing, maternity counseling and referral services; family planning; primary and preventive health services including pre and postnatal care, nutrition information and counseling; referral for screening/treatment of venereal disease; referral for pediatric care; education services in sexuality and family life; referral to educational and vocational services, adoption counseling and referral services, supplemental services include child care, consumer education and homemaking, and transportation.

In addition to providing for project grants, the legislation requires that the Department improve the coordination of Federal and State programs, including review of programs and policies which serve as barriers, and undertake a study of adolescent pregnancy and report to Congress on its findings in 1979.

The Director of this program, Dr. Lulu Mae Nix, was sworn in on October 31, in a public ceremony. Dr. Nix, as many of you know, has worked nationally in this field for many years from the base of the program she developed in Delaware.

Lastly, in that same closing session of Congress, a bill was passed to establish a Panel for the Promotion of Child Health. The Panel is to review all significant studies, formulate goals, and develop a comprehensive national plan for achieving these goals. It specifically states

"it is the intent . . . (that the Panel) will take into consideration the health care needs of expectant mothers as they relate to fetal development and the future of their children."

You can see that we have some busy months ahead.

I would like to close with a favorite quotation of mine:
Grace Abbott, who was Chief of the Children's Bureau 40 years ago, once spoke of the unequal odds she faced as the children's advocate in Washington. She envisioned Washington as a gigantic traffic jam of advocates all crowding up toward Capitol Hill to petition Congress for budgets. The Army had its tanks, trucks and gun carriers. The Department of Agriculture had its hayricks and ploughs. And the Department of State had its limousines. But all she had was her baby carriage. "I stand on the sidewalk watching it become more congested," she wrote, "and then, because the responsibility is mine and I must, I take a very firm hold on the handles of the baby carriage and I wheel it into the traffic."

We need many hands on the handle of that baby carriage today if we are to make it through the traffic. Your hands on that handle are welcome.